



**SUPPLEMENTARY HEALTH CLAIM FORM**

**INSTRUCTIONS:** Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.  
For **Out of Country** claims please contact Mondial Assistance at 1 (800) 265-9977 (Canada/U.S) or go to [www.manulife.ca/group\\_benefits/travel](http://www.manulife.ca/group_benefits/travel) for additional information and for participating countries.  
**Your claim will be returned to you if the claim form is incomplete.**

1. MEMBER INFORMATION					
PLAN SPONSOR / EMPLOYER NAME			GROUP NUMBER		
LAST NAME		FIRST NAME		CERTIFICATE NUMBER/SIN	
ADDRESS		GENDER Male Female	LANGUAGE English French	DATE OF BIRTH (MM/DD/YY)	
CITY		PROVINCE	POSTAL CODE	PHONE NUMBER	

2. PATIENT INFORMATION	
Does the patient have any other coverage which would pay a benefit for this claim?	Yes No
If yes, please indicate the date of birth of the insured:	(MM/DD/YY)
If yes, attach photocopies of vision receipts and the co-insurance statement.	
Is the treatment required as the result of an accident?	Yes No
If yes, indicate the accident date, location and details on how the accident occurred.	
Is the treatment required as the result of a work related injury?	Yes No
Is a claim being made for Worker's Compensation benefits?	Yes No

CLAIM DETAILS					
Patient Name (Last, First)	Relationship to Member	Date of birth (MM/DD/YY)	Type of Service	Date of Service (MM/DD/YY)	Total Charges

Do you want any unpaid portion of your claim processed through your Health Spending Account? Yes No

To ASSIGN PAYMENT TO SUPPLIER:	
I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier. (Name of Supplier)	
Member Signature _____	

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Manulife Financial to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

SIGNATURE OF MEMBER \_\_\_\_\_ DATE \_\_\_\_\_ (MM/DD/YY)

